The Secrets of Dr Rife's Resonant Energy Device

Some of the microbe-killing radio frequencies of Dr Rife's original ray beam device have now been duplicated with encouraging results.

Part 2

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EARLY DEVELOPMENTS IN RADIO-FREQUENCY DEVICES

In part one of this article, an overview of the electronic therapeutic device invented by Dr Royal Rife was given, together with an in-depth look at the modern-day counterpart of the original Rife device, the Rife/Bare device. The original Rife device has been a mystery for over 60 years, but now that mystery has essentially been solved.

To begin this account, an examination of a small piece of history is necessary to determine what the actual device was. Pre-dating Rife's electronic instrument was another device, developed in the year 1918 by Albert Abrams, MD.

Dr Abrams developed a treatment device known as the "Tick-Tock" Oscillator (for its metronome-like action). This was a shock-excited, low-power, short-wave-emitting instrument that operated in the 43-megacycle band. Over 2,000 of these instruments were distributed throughout the world. In 1931 he developed an improved instrument, the Oscilloclast, also operating in the 43-MHz band. This was merely a modernised version of the Tick-Tock Oscillator.

The Oscilloclast produced three types of waves: one type was a short wave (as in short-wave radio); the second was an impulse-excited, damped wave of about 90 Hz per minute or 1.5 Hz per second (think of this as a ringing bell); and the third was a kind of alternating magnetic energy. The radio energy emitted by the Oscilloclast was of very low power, being in the milliampere range and incapable of producing a heating effect. The short-wave radio energy in the Abrams device was generated with a 50 per cent duty cycle; that is, the power is on for as long as it is off. This energy was pulsed at a rate of 90 Hz per minute. One could easily think of this as a continuous wave (CW) transmitter, outputting sequentially spaced dashes generated by closing a telegraph key every 1.5 seconds. In other words, the pulse was 0.75 seconds long and was then off for 0.75 seconds. The 43-MHz carrier wave, which was pulsed 1.5 times per second, was modulated by the ripples in the half-wave 60-Hz AC power from the wall socket; meaning that a 60-cycle tone—again, a 50 per cent duty cycle—was carried on the radio wave. One could hear this 60-cycle tone in a radio receiver tuned to the 43-MHz frequency of the transmitter.

The Oscilloclast also provided a pulsed, alternating magnetic energy through a pair of depolarising electrode plates. The magnetic energy could be measured at about 80 gauss close to the device. The electrodes were placed in close proximity to, if not actually touching, the patient. The depolarising electrodes had a choke coil to prevent the radio waves from entering the circuit. In order to treat a disease, the Oscilloclast operator would vary the output frequency of the short-wave transmitter in 10 steps from about 43.000 MHz to 43.357 MHz. The frequency chosen was of course based on the patient's complaints.

To sum all this up, the Oscilloclast was a low-power radio transmitter with a variable radio frequency output. The device produced a gated train of radio frequency pulses that were modulated with a 60-Hz audio frequency wave, and the patient was connected to alternating magnetic energy depolariser electrodes of about 80 gauss with a 1.5-second cycle.

To some people reading this explanation of the Oscilloclast, it should be apparent that what Dr Abrams invented was a very early version of a nuclear magnetic resonance (NMR) instrument. Modern magnetic resonance imaging (MRI) scanners use a fixed magnetic field with a variable frequency pulsed radio energy to make their pictures of the interior of the body.

Now that we know all that, what does it have to do with the original Rife device? I

believe that the original Rife device is a direct derivative of the Abrams device. There are some slight differences—namely, the power levels are many times greater in the Rife unit—yet the emanated radio wave from the plasma tube is very slight, like in the Abrams device. The Rife unit had a variable pulse rate of from about 1 to 4 Hz per second; it used a much wider variation in the radio frequency band than did the Abrams unit; and Rife used a plasma tube as an antenna. Mortal oscillatory rates (MORs) were given only in radio frequencies, as originally there was no (modulated) audio frequency MOR.

It is my thought that the reason Rife never patented his device was due to its extremely close kinship with the Abrams Oscilloclast and another device of the era, known as a Violet Ray device.

The Violet Ray device was simply a handheld Tesla coil attached to an argon-filled glass tube. The Tesla coil produced damped, shock-excited oscillations in igniting the tube. Due to its construction the Violet Ray, like the Oscilloclast, would modulate 60 Hz AC wall power. Large versions of the Violet Ray device were apparently pioneered by Nikola Tesla as a therapeutic device in the late 19th century.

So how did the original Rife device operate? Nowadays we all think in terms of audio frequency MORs. For example, the known audio MOR of cancer is 2,128 Hz. But Rife gave an MOR of 28,825,455 Hz. In other words, there was no direct modulation of an audio frequency with the original Rife device!

The original Rife device merely used a variable radio frequency with a variable pulse rate. This pulsed radio wave was output to a gas-filled tube. The pulse was generated by controlling the output of the transmitter to the plasma tube. In an available video of Dr Rife using his unit, the pulse of the tube can clearly be seen. This pulse was a complete on/off cycle, and the tube did not stay lit between pulses. Such a shock will produce immense radio-energy harmonics.

How and why the variable audio MORs used today came into being is still unknown. But certainly, the fact that a 60-Hz modulated wave was important to the Oscilloclast's operation had to play some part in the development of the audio MORs in the Rife device.

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ILL-FATED RESEARCH WITH A RIFE-TYPE DEVICE

A recent series of letters from an individual known by his Internet name as "Cisco" has shed even more light on the original Rife instrument. In 1934 two doctors in Denver, Colorado, respectively named Clayton and Cooperson, were working with what is assumed to be a Rife instrument.

Several years ago Cisco was given access to Dr Clayton's seven notebooks. Cisco took notes from these notebooks as they seemed to be important, but no mention of Rife was ever made in the entries. Cisco later found out that Dr Clayton's relative, who owned the notebooks, had thrown them in the trash!

Cisco's story of Dr Clayton is most revealing. Besides the plasma tube, the radio transmitter and the variable pulse rate, Clayton connected his patients to a couple of alternating depolarisers.

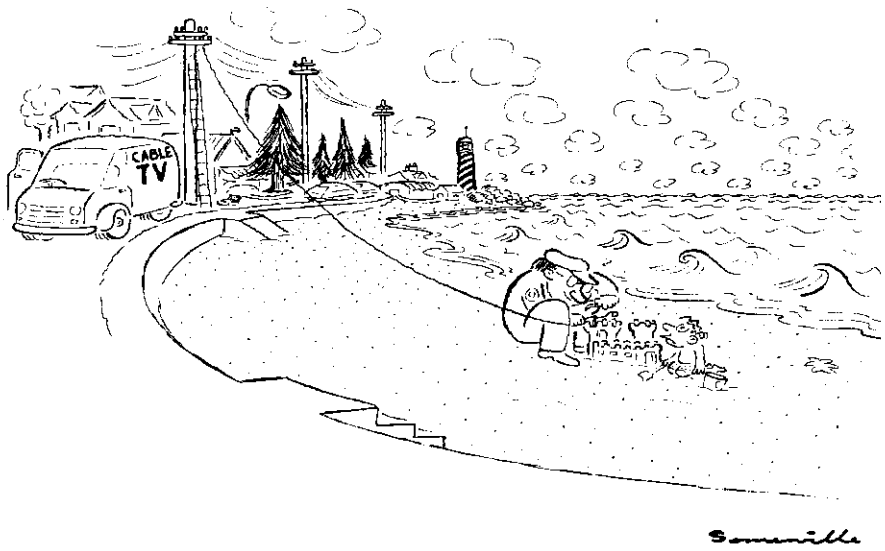
The depolariser was designed to deliver an alternating DC electrical current that would change from positive to negative as the radio-energy-driven output bulb pulsed. The output of the depolariser would appear much as a square wave would look on an oscilloscope; that is, the pulse would be positive for half of the time of a flash cycle and then abruptly become negative for the remaining half of the cycle when the tube wasn't flashing.

The patient would sit in a wooden chair with his feet on a metal plate and would hold two electrodes in his hands. At a later date, a pair of electrodes was added to the back of the chair to get more current into the torso area. The use of a foot plate and handheld electrodes is an application technique typical of modern electric-current Rife-type frequency devices.

Dr Clayton and his partner Dr Cooperson later became caught up in the politics of the situation. They suffered from the economic reality of the Depression, and research slowed. The final straw was that the US Government threatened both doctors with prosecution on sedition charges.

In order to raise funds, the two doctors had become involved with a rather mysterious but wealthy German, and a Swiss financier. They had also had frequent contact with a German microscopist. Problem was, of course, that the good doctors were dealing with people in what had become Nazi Germany. In retrospect, their innocence of the situation was certainly something of their undoing, but this was the Depression and money was scarce.

As an example of how economically stressed things were in this era, one major American newspaper magnate was receiving payments from Nazi Germany to print favourable articles in his newspapers about the Nazi regime.



The US Government finally confiscated Clayton's and Cooperson's equipment and lab notes as it considered them a security threat. Cooperson committed what was deemed a suicide in 1940, and Clayton was poisoned shortly thereafter. Clayton's death was initially listed as a suicide, but later lab tests showed the presence of a rather nasty poison cocktail in his system. Did the US Government do this foul deed, or did the Nazi regime? Only history knows the answer.

DETERMINING THE MORTAL OSCILLATORY RATE

One of the most significant facts to come from Dr Clayton's journals is how the microscope that Dr Rife invented was used to determine MORs. By using a pair of counter-rotating prisms under the microscope stage, a projected beam of monochromatic light could be emitted into the specimen on the stage of the microscope. At a certain colour, the cell would re-radiate a different colour. This was done with live cells and could be considered staining with light, or a variant of what is known as "Rheinberg illumination".

In the Rife microscope the cell would be coloured, and the remaining field would be white as in a standard bright-field microscope. When the MOR was reached, the cell in question would lose its colour and become clear as it absorbed the resonant energy and changed or died.

That is the technique Dr Rife used to find his MORs, and certainly it has applicability today with modern microscopes.

For those who would think of replicating Dr Rife's original instrument, some radio frequency (RF) MORs are known. These frequencies are directly from Rife's notebook. In his notebook are two frequences, and it is believed that the frequencies were combined in either the final output stage of the transmitter or were injected simultaneously into the globe plasma tube. One of the frequencies is given directly, and one of the frequencies is given indirectly as a wavelength of the super-regenerative audion tube.

Wavelength is converted to frequency by this formula: Frequency (Hz) = the speed of light in metres per second divided by the wavelength in metres; i.e., frequency = 3 x 10^8 metres per second / wavelength.

There is a complication here, known as heterodyning, and if the frequencies are to be combined within the plasma tube then one must account for this possibility. With heterodyning there could be another wave emanating from the tube that is the difference between the two frequencies and not their sum.

Carcinoma: 11,780,000 Hz; wavelength of the super-regenerative audion tube is 17 and 6/10 metres, or 17,045,455 Hz. The MOR is therefore 28,823,455 Hz or 5,265,455 Hz.

***Streptococcus*:** 1,241,000 Hz; wavelength of the super-regenerative audion tube is 142 metres or 2,112,676 Hz. The MOR is therefore 3,353,676 Hz or 871,676 Hz.

***Staphylococcus*:** 998,740 Hz; wavelength of the super-regenerative audion tube is 540 metres or 555,556 Hz. The MOR is therefore 1,554,296 Hz or 443,184 Hz.

Tuberculosis: 583,000 Hz; wavelength of audion tube is 554 metres or 541,516 Hz. The MOR is therefore 1,124,516 Hz or 41,484 Hz.

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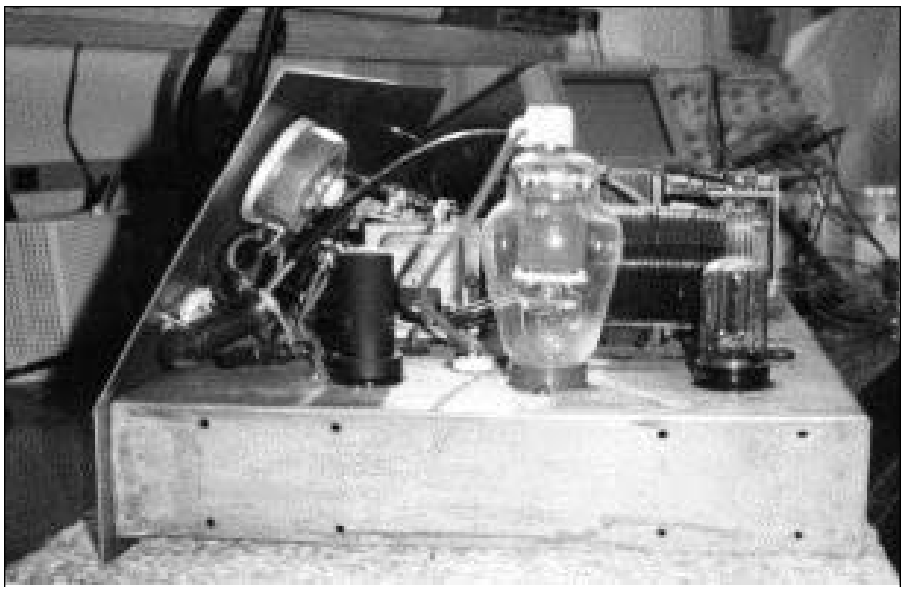
RIFE DEVICE REFINEMENTS

My present thought is that an optimised device could be constructed using a variable frequency radio transmitter with modulated square-wave audio MORs and a variable audio pulse rate.

My device, the Rife/Bare unit (I didn't name it this; people using one of my devices did) is much like this. A gated audio pulse can be generated with modern audio frequency oscillators, while the pulse rate of the carrier wave varies automatically with the applied audio frequency. The RF pulse can be adjusted electronically for its "duty cycle". My instrument also has a fixed radio frequency of 27.12 MHz. A variable radio frequency will most certainly create all sorts of radio interference and cause oneself some legal problems if the device is not properly shielded for RF emissions.

I must warn potential constructors of the original Rife unit that the device should not conform tightly to known radio operational aspects. The original Rife device from Clayton's journals was something like my device and was quite temperamental.

For my device to work properly and optimally, the device must be self-resonant. Precise cable lengths, position and types of components, grounding circuits and feedback loops of the radio energy are necessary for my device to work. These variables have been determined for my device, and all one needs to do is to follow the instructions. Finding these variables for a re-creation of the original may be quite problematic.



Original Rife beam ray unit of about 25 watts power; uses 809 output tube.

FUTURE OUTLOOK

I realise that this information is highly controversial. Over the years, so much has been written about the Rife device that is misleading or erroneous that it has become hard to determine fact from fiction. Re-creating the original Rife device will be quite an undertaking.

The true tragedy of Dr Rife is that his research was lost. We are over 60 years behind where we should be with the development of Rife's instruments.

The worldwide toll in human lives and suffering in the past 60 years is too great to be imagined, too horrifying to be comprehended. The future of my device is secure: far too many copies of my book, telling people how to make the device, are in circulation.[1] Far too many people have a device and also know how to make the device. These same device-savvy people no longer need a book to guide them and are located diffusely in various countries around the world. There is no way to stop what is about to happen.

Since August 1997, the first Rife/Bare devices have been constructed in Russia, China, Indonesia, Saipan and Vietnam. In mid-October 1997, the world's first Rife Technology Symposium was held in Canada, with 148 people attending from a multitude of countries around the world including England, Australia, the Netherlands, Canada and the USA.

It was rather nice to have PhDs, MDs and DCs all working together, but, better yet, it was the *non* health care professionals who made this event happen, and it was from this group that nearly all the device's growth has come. This is the same group whose members ante up a lot of their money every year to fund all sorts of medical research that does them little good. This is also the same group that, as time goes on, will see that some money is redirected to *health care* research (there is a difference!) and the growing worldwide use of the device.

I will not make specific predictions about the future and how the machine is about to change it. The course is set and we are moving towards a new shore, but how we finally get there is a question that destiny must decide. ∞

Endnote

1. Bare, James, DC, *Resonant Frequency Therapy: Building the Rife Beam Ray Device*, James Bare, Albuquerque, NM, USA, 1995-96.

About the Author:

James E. Bare is a Doctor of Chiropractic who has been practising for over 20 years in Albuquerque, New Mexico, USA. An electronics tinkerer since his early teens, he set to work on a prototype Rife instrument after reading Barry Lynes' book on Rife in late 1994. By mid-1995 his prototype unit worked well with pain and muscle relaxation. By late 1995 he added overmodulated pulse to the device, and from then on his Rife/Bare device started producing astounding health effects, though he does not use it to treat patients in his chiropractic practice. Bare works an average of 100 hours per week, with device-related matters occupying two-thirds of his time. He believes he is able to work such long hours because of the vitalising effects of exposure to the device.